Military Children and Youth Symposium

Peterson Air Force Base, Colorado
April 15, 2011

21FSS PETERSON AFB FORCE SUPPORT SQUADRON

ISFAC
Inter-Service Family Assistance Committee

OPERATION: MILITARY KIDS
MILITARY FAMILIES IN OUR OWN BACKYARD.

FORT CARSON THE MOUNTAIN POST

SCHRIEVER AIR FORCE BASE FORCE SUPPORT SQUADRON

Military Families: Fostering Social Emotional Health While Meeting Cultural Needs

Marjorie Knighton, LPC
AspenPointe Counseling Services

April 15, 2011

- **AspenPointe Counseling:**
  - We have a specialized staff working with military children and families

- **AspenPointe Child and Family Early Childhood Specialist working with military families:**
  - In collaboration with CPCD therapeutic preschool
  - Mental Health First Aid training

- **AspenPointe Lighthouse Acute and Dual-diagnosis Units:**
  - Two units serving military involved adults with mental illness or dual diagr including substance abuse and mental health;

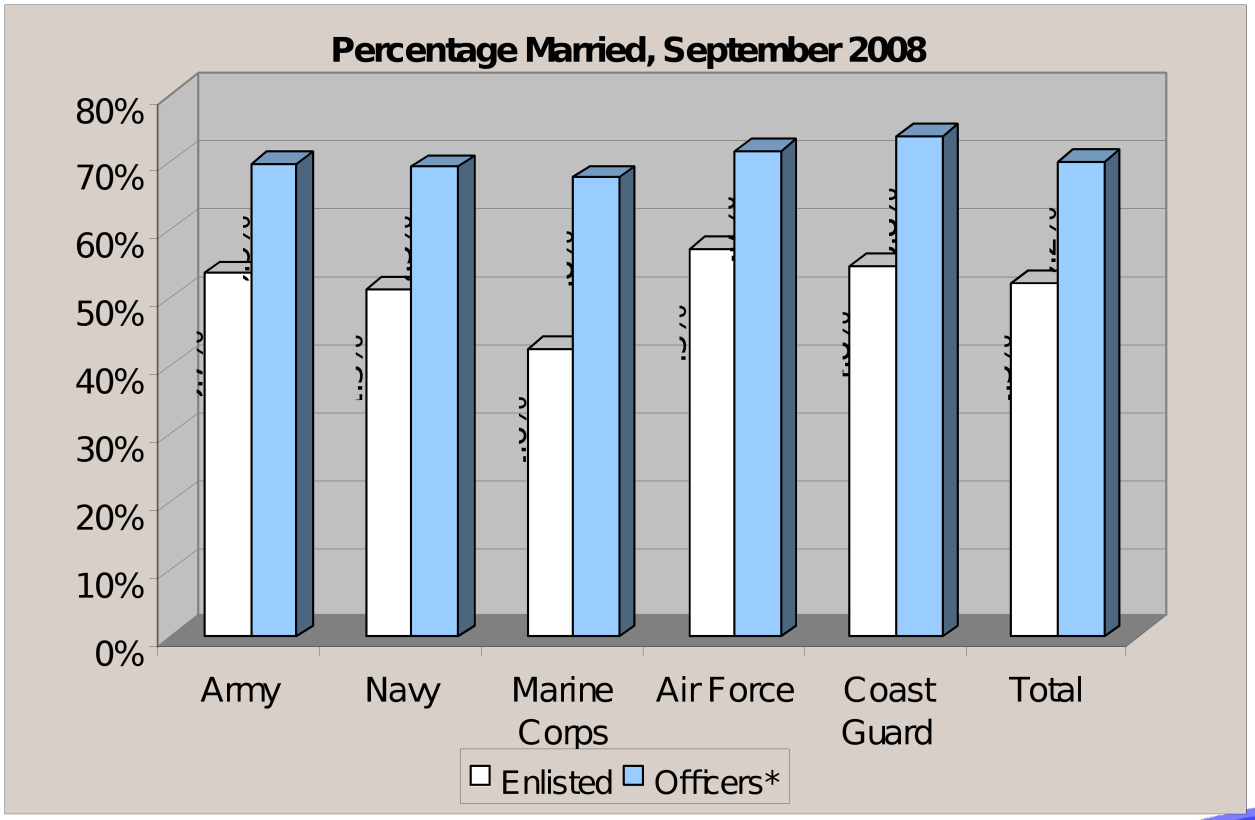
- **Peer Navigator Model:**
  - Developed to serve the needs of military and their families through real connections to supports both within the military and civilian communities.

- **We recognize:**
  - How well the family does at home is how well the soldier will do during deployment.
  - Rapid communication technology brings the war closer to home and the home closer to war.
  - This is a war that we are all a part of – civilian and military.

Presentation Overview

A. Understanding the Population We Serve
B. Specific Issues and Lessons Learne
C. Clinical work within the cultural framework of the Military
D. Parenting Skills and Intervention
E. Vision for the future

Marital Profile of Active Duty Forc



52% are married

13% of the married couples are in dual-military marriages.**

* *Includes Warrant Officers*

- Numbers do not equal 100% because other marital status not listed.

US Army Community and Family Support Center, 2005, p. 6)

Military Marriages

Washington Times, November 28, 2009 reports:

The divorce rate in the armed forces increased slightly in the past year as milita marriages continued to bear the stress of the nation's ninth year at war with a divorce rate of 3.6%, which is a full percentage point above the 2.6% reported in 2001.

Military Families

1. 43% of the active duty have 1 or more children.*

2. 79% of married active duty have dependent children.
   - 63% have children ages 3-10
   - 37% have children ages 11-15
   - 27% have children ages 16-18 and
   - 13% have children ages 19 and older

Source: (Dept. of Defense, 2006, p. 42, 96)* and US Army Community and Family Support Center, 2005.

Issues That Arise and Lessons Learned

Issue: Deployment Cycles

1. Of those whose soldier spouse had been away on a military operation:
    - 8% said the soldier was away for 6-11 months;
    - 38% said 12-17 months; and
    - 13% said 18-36 months

2. 51% of spouses who have recently experienced deployment were separated for 12 or more months.

3. Rapid-cycle deployment – a new war process
    - Post-Deployment Cycle / Pre-Deployment Cycle merge and also require ADSM to be away from family while in USA.

Source: US Army Community and Family Support Center, 2005, p.4

Lessons Learned: Deployment Cycles

1. Needs of families vary depending on phase of deployment cycle, length of deployment, frequency of deployment and dangerousness of the mission.

2. Balance, communication and trust remain the key elements of good therapeutic intervention regardless of cycle.

3. Pre-military coping skills can be predictive of style of coping during stressful times in military.

4. Families with strongest pre-deployment marital relationships do much better on return than those with weaker pre-deployment relationships.*

5. 53% of spouses rate reunion adjustment as ‘easy’ or ‘very easy’; while 16% rated it as ‘difficult’; and 7% ‘very difficult’.*

6. Least successful post-deployment relationships do not access reunion support of the military.*

Source: SAF V Survey Report: Reunion Adjustment Among Army Civilian Spouses with Returned Soldiers – Army Family Reunion Report, 2005, Othner and Rose.

Issue: Maintaining Deployment Readiness

1. There is a need and expectation that the active-duty member will be deployable at fullest potential and capacity.

2. Not all therapists have aligned their thinking and therapeutic intervention to incorporate the military mission mindset in the context of treating the family.

3. Military families frequently relocate, on average every three years*

Source: www.marinecorpstimes.com/news/2009/07/ap_children_mental_health_0709/ *

Lessons Learned: Maintaining Deployment Readiness

1. How well the family does at home is closely tied to how well a soldier does during deployment.

2. Successful providers support both the family and active duty service member, and recognize the importance of readiness for duty.

3. Most children are resilient and adaptive despite the challenges related to military deployment.

4. We have learned that certain needs especially around safety and belonging seem to have children more at risk for mental health problems (i.e. multiple deployments, frequent moves, parent injury or death).*

Source: Adjustments among adolescents in military families when a parent is deployed, 2005, Huebner and Mancini.

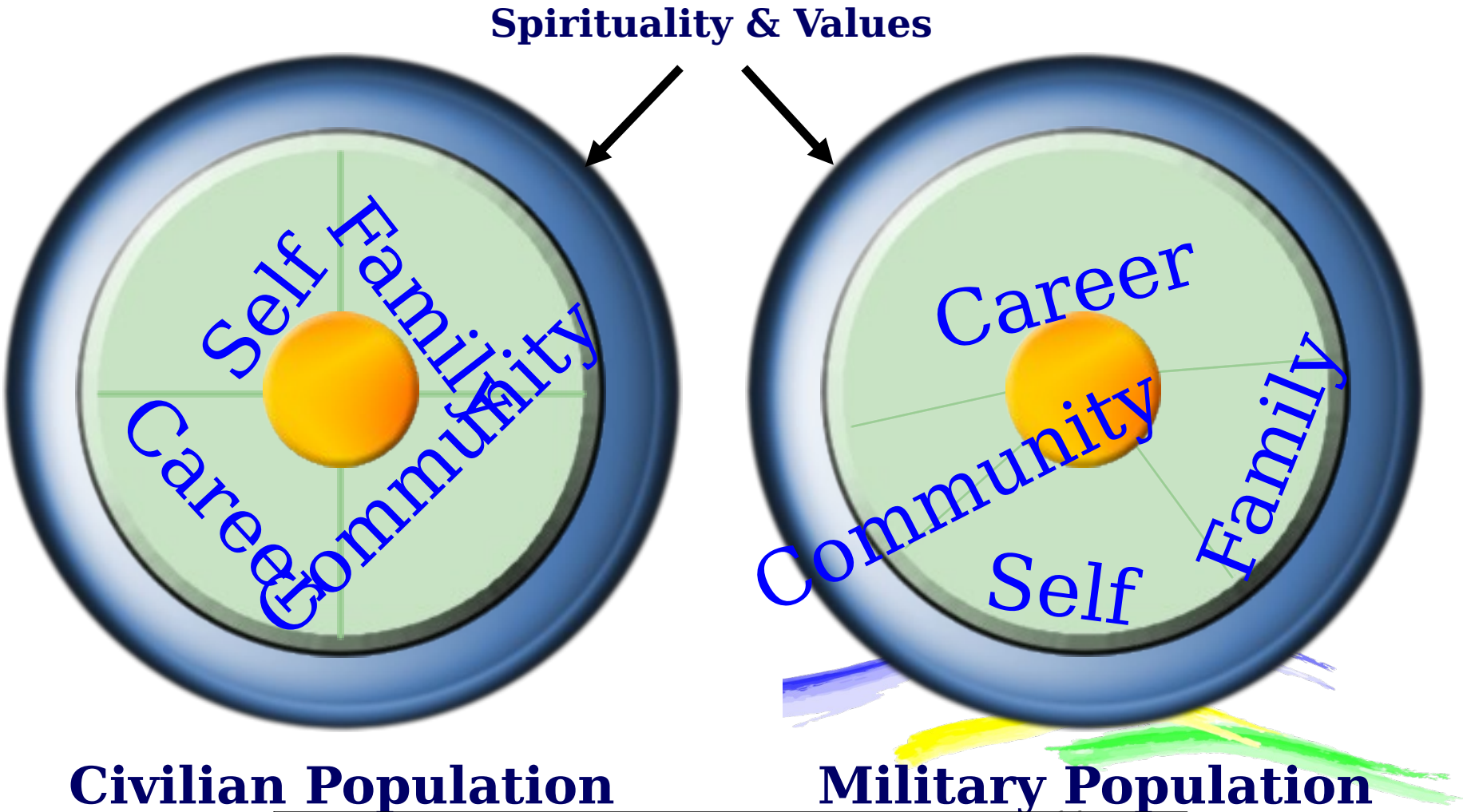
Issue:
Life Balance

1. Maintaining the Balance of Mission, Family, Self and Community are common issues for military families.

2. Military expectations sometimes supersede family, personal and community needs.

3. When addressing the life balance of a military families, therapists can adapt life balance theory models to illustrate challenges.

Lessons Learned: Balancing Mission, Family, Self and Community.

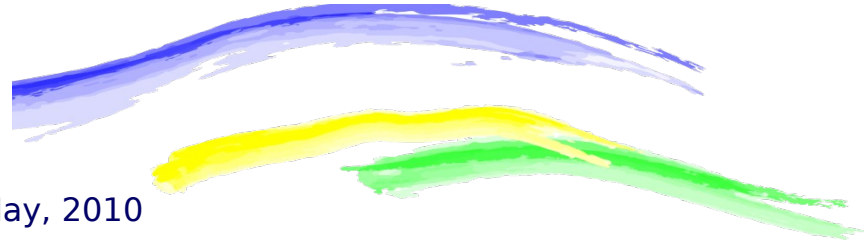


Civilian Population **Military Population**

Borrowed from Center for Creative Leadership Model for Life Balance

Issue:
Role Definitions for Parent, Spouse and Child

1. Being married yet a single parent
2. Being married but limited opportunities for intimacy
3. Younger families often:
   a) More chaotic
   b) Less defined
   c) Fewer life experiences
   d) Single parents more vulnerable during deployment
4. Child maltreatment is more frequent during deployment than during post-deployment. *
5. The mental health status of the at-home parent during deployment impacts the mental health of children under their care.



*Source: Trauma Faced by Children of Military Families, May, 2010 Sogomonyan and Cooper

Lessons Learned:
Role Definition for Parent, Spouse and Child

- Outpatient mental health visits provided to children of active duty parents doubled from one to two million between 2003-2008.
- Total days of inpatient psychiatric care for children (14 and under) of active duty increased from 35,000 in 2003 to 55,000 in 2008.
- Children 11 to 17 were found to have a higher prevalence of emotional and behavioral difficulties than the general population.
- 1/3 of children with a deployed parent are “at risk” for psychosocial iss
- Learning to co-parent again is difficult for 1/3 of military families - especially reestablishing parenting roles and sharing in discipline.*
- Parents who describe their families as strong are more likely to also report that their child coped well with deployment.

Source: Trauma Faced by Children of Military Families, May, 2010 Sogomonyan and Cooper:

*SAF V Survey Report: Reunion Adjustment Among Army Civilian Spouses with Returned Soldiers – Army Family Reunion Report, 2005, Othner and Rose.

Lessons Learned: Role Definition for Parent, Spouse and Child

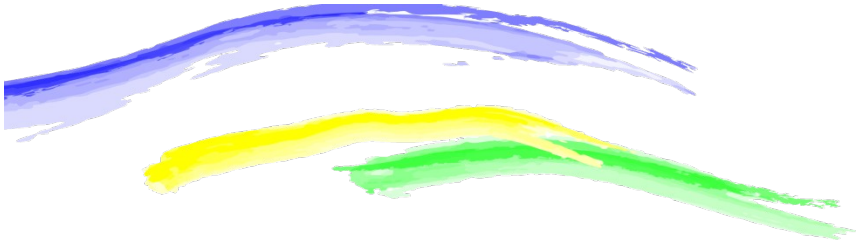
Two family types have surfaced: **1. "Large and In Charge"**

- Tend to do well during deployment because of strong organizational, personal and business skills.
- May grow independent of need for spouse or parent supports and may struggle with role alignment upon ADSM return.
- May tend to protect deployed spouse or parent from family issues which can have both positive and negative results:
  - Positive: Sheltering soldier from family issues, keeping soldier focused on mission;
  - Negative: Deployed soldier feels left out of parenting role.
- Tend not to come to treatment until post deployment period due to reintegration issues.
- Therapeutic Intervention focuses on communication, understanding personality style, family and/or individual therapy

Lessons Learned: Role Definition for Parent, Spouse and Child

Two family types have surfaced: **2. “Overwhelmed and Fragi**

- Tend to struggle during deployment, increased chaos, regression and expression of extreme personality features.
- Tend to present earlier and in crisis for therapeutic issues.
- Therapeutic intervention should focus on communication, real life supports, and individual skill building.
- May turn to self-harming behaviors and/or suicidal i n.
- Couples, family, and/or individual therapy, as well as, Group programming specific to skills building.

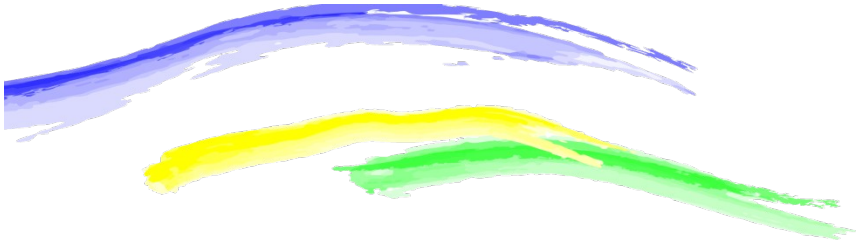


Issues:
Raised Voice, Commanding and Physical Confrontation

1. Civilian organizations do not typically thrive on models of leadership that allow yelling, commanding and intense physical confrontation.

2. Parenting and marital relationships are not typically felt to be healthy in an environment of raised voices, commanding and intense physical confrontation.

3. Military culture has clear examples where commanding and physical confrontation, including violence, are endorsed and accepted.



Ten Tips for Supporting Children of Deployed Soldiers – Hardaway, February, 2003 BAMC

1. Talk as a family before deployment.
2. Bestow, rather than “dump” responsibilities on remaining family members.
3. Make plans for the family to continue to progress together, and include the deployed parent in ongoing projects.

4. Continue family traditions and develop new ones
5. Help children understand the finite nature of deployment by devising developmentally appropriate time-lines.

6. To children, no news is worse than bad news.
7. Listen to a child’s worries about the deployed parent and answer questions as truthfully as possible.
8. Maintain firm routine and discipline in the home.
9. Initiate and maintain close relationships with the school and teacher.
10. As the remaining parent, make sure you take care of yourself.

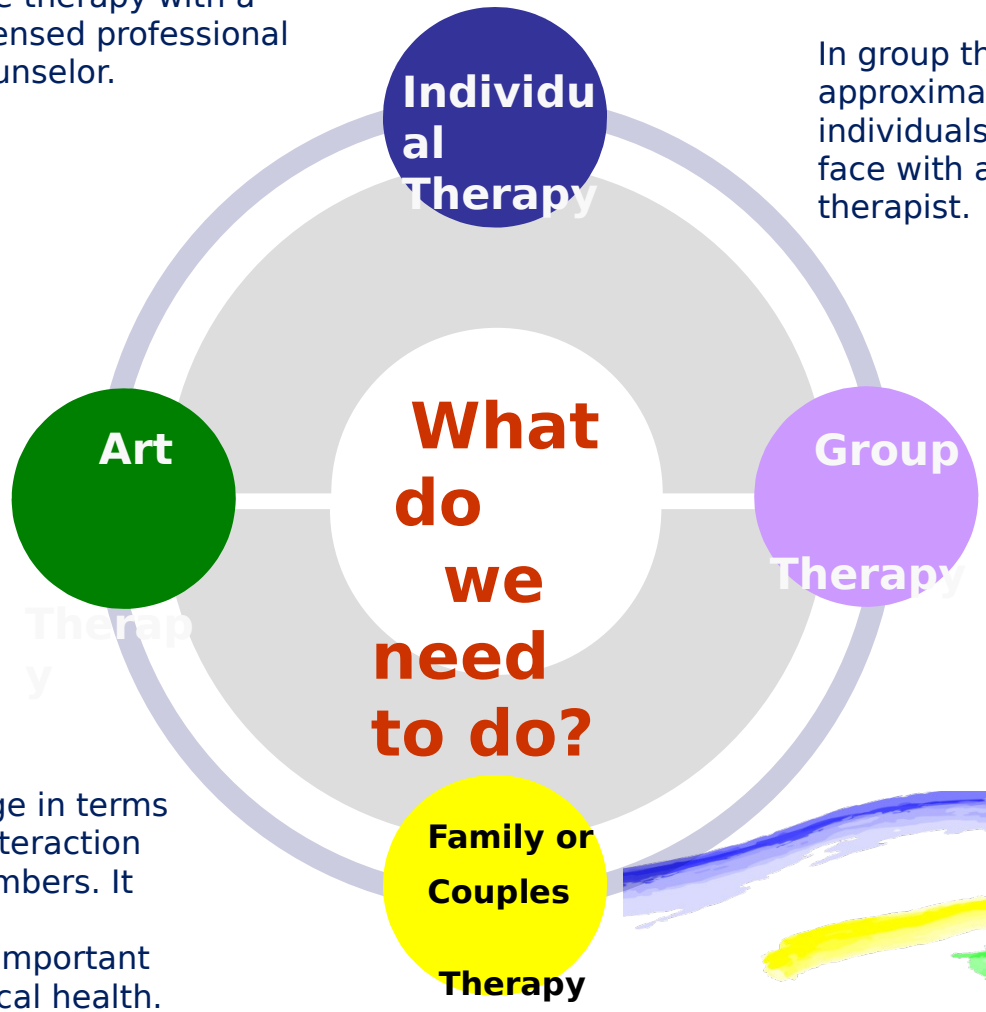
Therapeutic Interventions

Confidential, one-on-one therapy with a licensed professional counselor.

In group therapy, approximately 6-10 individuals meet face-to-face with a trained group therapist.

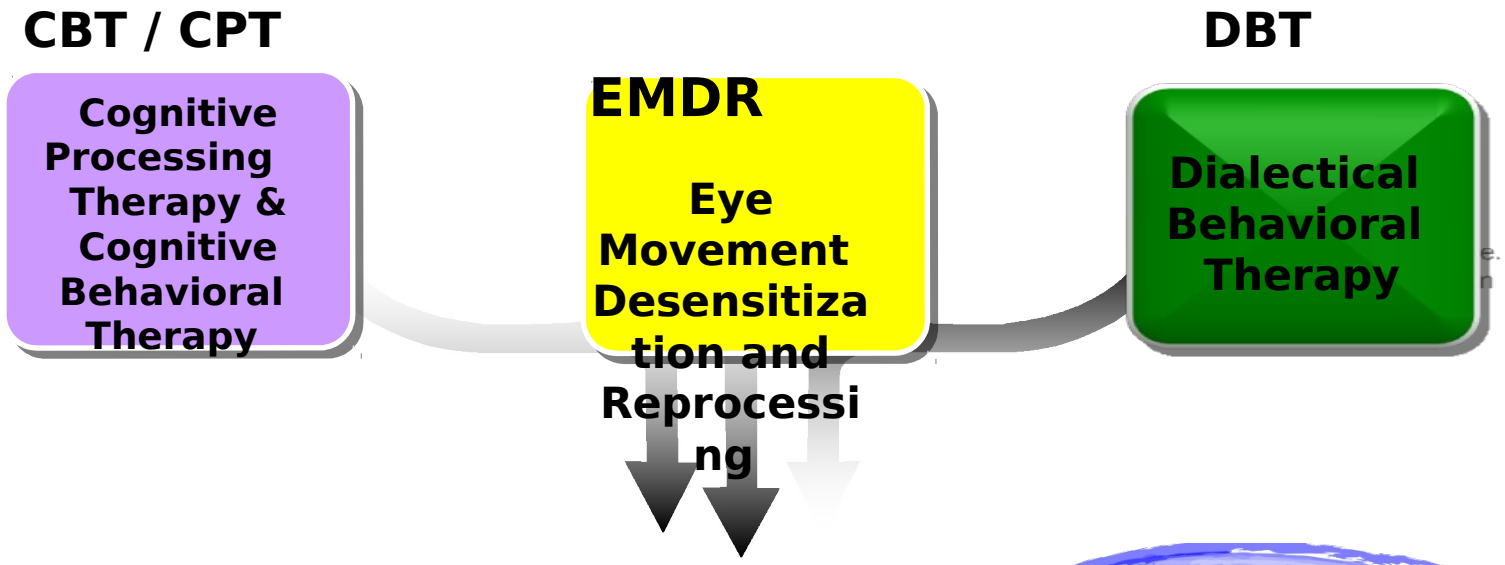
Art therapy is a form of creative expression that uses art materials such as paints, chalk and markers.

Tends to view change in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health.



Therapeutic Interventions

AspenPointe has the unique ability to support our clients by offering a mental health therapist in conjunction with a nurse prescriber, if medications are needed.

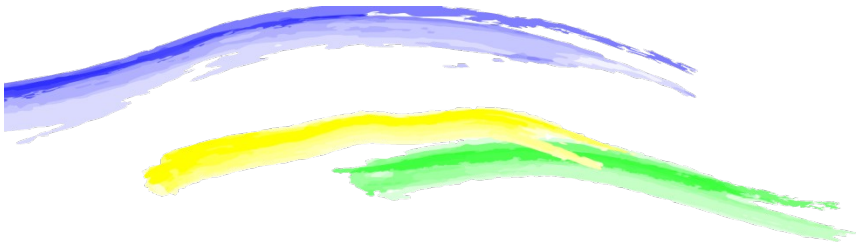


"Empowering clients. Enriching lives. Embracing purpose."

AspenPointe Contact Information

Call Center:
(719) 572-6100 or (800) 285-1204
www.aspenpointe.org

- AspenPointe Counseling
- AspenPointe Child & Family Services
- Early Childhood Specialist
- AspenPointe Lighthouse Acute
- Dual-Diagnosis Units
- Peer Navigator



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Attachment Disruption & The Combat-Ready Family

A. ELAINE CRNKOVIC, PHD
CEDAR SPRINGS HOSPITAL

“Disruption”

A World of Uncertainty

- Our children do not know a world in which we are not engaged in a war
- Time and Location of Deployments
- Safety of Deployed Parent
- Deployment Anxiety About the Future
- Reunion Anxiety About Changes
- Results in Attachment Disruption

The “Phantom” Parent

- Conversations While Deployed
  - May be Superficial or Focused on Positives Only
- Who Takes the Authority Role
  - May Change with Each Deployment
- Reunion and Reintegration
  - May be Complicated by Deployed Parent’s Sense of Responsibility

Emotional Distress

- Realistic Fear of Death or Injury to Deployed Parent
- Repeated Grief and Loss
  - More than typical children experience
  - Is cumulative
- Hypervigilance of Being Combat-Ready
- Pressure to Make Every Moment Count

Anxiety Travels On The Same School Bus

- Change is Frequent in the School Setting
- Allowance of Time to Adjust is Critical
- Open and Honest Communication About Real Fears
- Structure is a Must; TYPE of Structure Needed Changes
  - Need for Teacher-Imposed Structure Versus Self-Directed Structure Within Guidelines Changes

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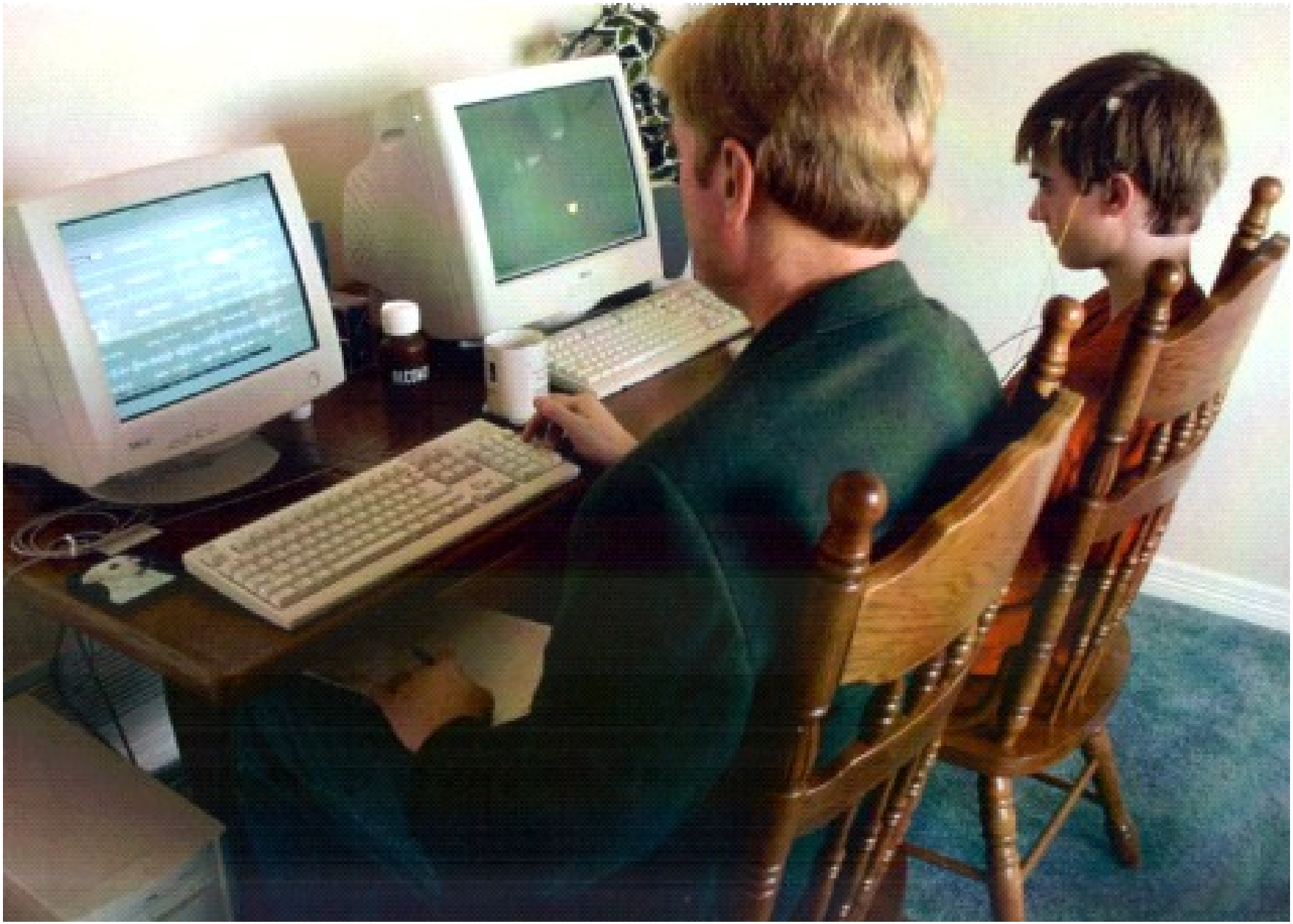
University of the Rockies

Steven Gray, Ph.D.

Diplomate, American Board of Pediatric Neuropsychology

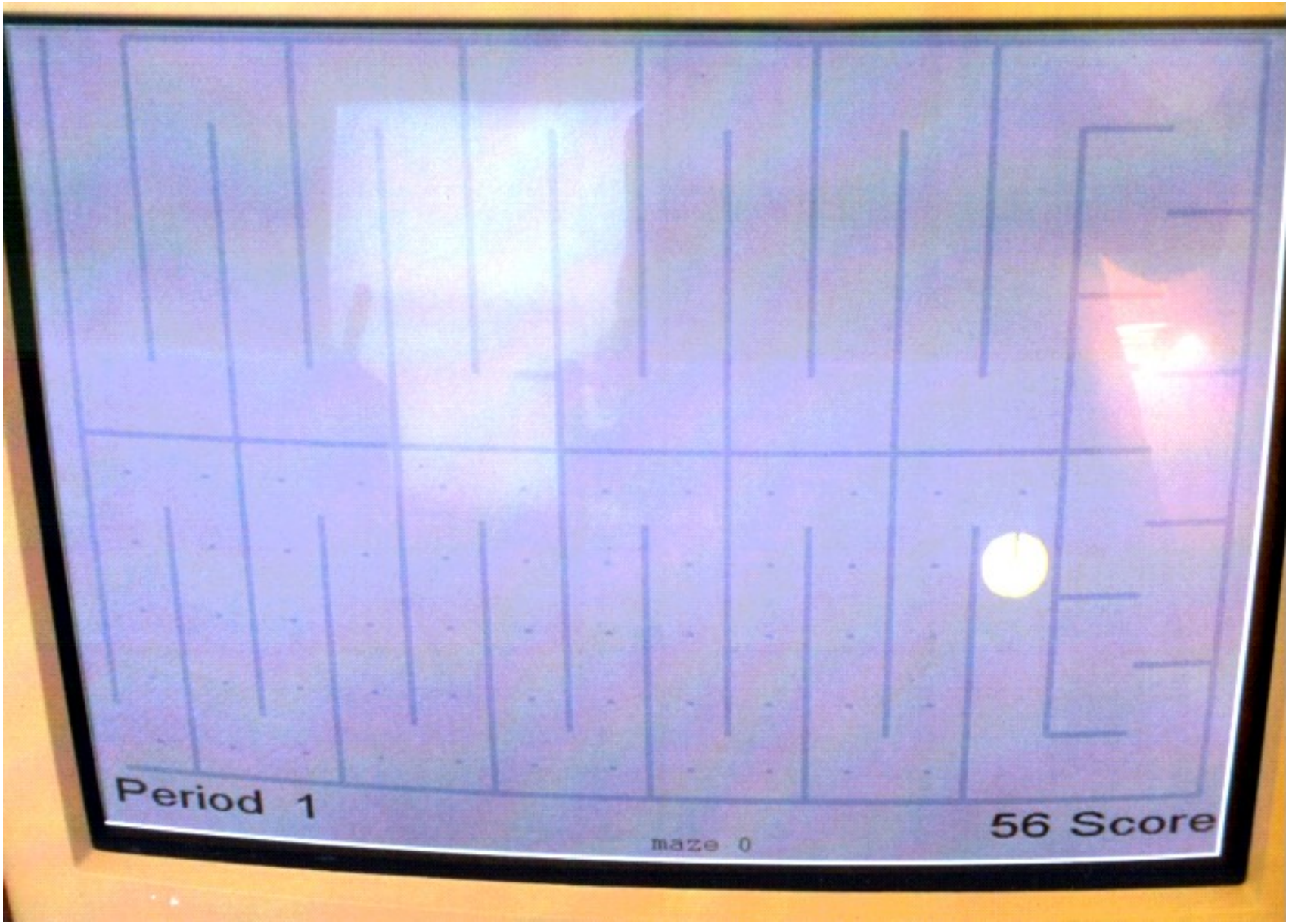
Professor, University of the Rockies

Clinical Assistant Professor, University of Texas Southwestern Medical Center



Neurofeedback

- **Origin:** initial research done in late 60's (Dr. Barry Sterman at UCLA).
- **EEG:** electrical activity in brain ("brainwaves").
- **Biofeedback:** feedback on some portion of our biology (muscle tension, blood pressure, sweat gland activity, brain electrical activity, etc).
- **Neurofeedback**: giving a person feedback – on a moment to moment basis – of



Mazes

Classes of Pediatric Psychotropic Medications

- **Psychostimulants** (Ritalin, Adderall, Concerta, etc.)
- **Anti-hypertensives** (Clonidine, Tenex, etc.)
- **Anti-depressants** (Zoloft, Paxil, Lexapro, Strattera, etc.)
- **Anti-convulsants** (Neurontin, Depakote, Lamictal, Gabitril, Topamax, Tegretol, Trileptal, etc.)
- **Atypical Anti-psychotics** (Risperdal, Seroquel, Clozaril, Geodon, Zyprexa, Abilify, etc.)

Psychotropic Medications

Three types of parents contemplating psychotropics for their children:

1. Pro-meds
2. Anti-meds
3. Ambivalent

Baylor University

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Impact of Deployment on Military Families: Recent Research Highlights & Current DoD Research Ft. Carson Behavioral Health Child and Family Programs

LTC Erin V. Wilkinson, Psy.D
Chief, Child and Family Programs
Evans Army Community Hospital

Panel Members: COL(R) George Brandt, M.D.

Dr. Ken Delano, Ph.D

Acknowledgments

Child and Family Assistance Center

- **Mission**: the Child and Family Assistance Center will provide a comprehensive integrated behavioral health care delivery system to treat military children and their families in the Colorado Springs area through both a School-Based Behavioral Health program and Behavioral Health Family Clinics

- **Vision**: The CAFAC will be a fully integrated, comprehensive behavioral health system for active duty family members (children, adolescents, adults, and the families) which will improve access to care, reduce stigma, provide services tailored to the unique needs of the military family, and be synchronized and aligned with the ARFORGEN cycle.

CAFAC and SBHP Objectives

- Provide a variety of behavioral health resources under a single umbrella with a single point of entry

- Coordinate services to improve access, capability, and flexibility and collaborate with post and community resources for long-term sustainability
- Reduce stigma associated with behavioral health care

- Provide outreach services to improve the behavioral health and well-being of the military community both on and off post

- Assist in training primary care providers in early identification, treatment, and coordination of care for behavioral health concerns

The Need

- Congressional Mandate passed in 2009 to implement Behavioral Health Programs and implement services targeting Active Duty Family Members and initiate school based services - Pilot programs implemented by 2012
- No BH treatment services available to ADFMs on Ft. Carson
- Network care not integrated into the military health care system
- 72% of ADFM reside off post
- No coordinated means to incorporate off-post care with the life style of the military
- Budget cuts put additional strain on resources within the school system
- Ft. Carson, Ft Lewis and Ft. Wainwright submitted pilot programs
- Proposal to MEDCOM to develop a Child and Family Assistance Center and a School Based Behavioral Health

MILITARY CHILD DISTRIBUTION BY SCHOOL DISTRICT

SCHOOL DISTRICT		09-10	10-11	% mil/total pop
FOUNTAIN/FT CARSON	D-84283	4428		58.8%
WIDEFIELD	D-31881	2052		22.8%
HARRISON	D-21218	1338		12.0%
COLORADO SPRINGS	D-11	1835	1825	6.4%
CHEYENNE MOUNTAIN	D-12	659	482	10.6%
ACADEMY	D-20	NA	3072	13.3%
FALCON	D-49	NA	2244	15.3%

- Total Military Children in your schools : **15,441**

ADFM	$2,657,881	$3,084,973		$4,045,854		42989	46538		90928	2647		
2008	**2009**		**2010**	**2008**	**2009**		**2010**		**2008**			

Annual Rate of Change	14.3%	21.6%	9.8%	54.4%	12.3%	10.9%

Mood/Depressive Disorders (not incl Bipolar)	$400,374.00
Adjustment Disorders	$370,730.00
ADHD/child disorders	$356,341.00
PTSD/Anxiety Disorders	$228,794.00
	$1,356,239.00

Child and Family Assistance Center

- **Implementation Phase I:** 2nd Qtr FY11
- **Location:** 4th Fl Evans; Appointment hours: 0800-1700 (5 p.m)
- **Services**: Medication evaluation, Individual, Family, Marital Therapies, Groups – parenting, marriage, PTSD support, etc, Assessments, Triage – screening/walk-in; 24hr On-Call ER support; Consultation
- **Current Staffing:** 2 Child Psychologists, 1 Child Psychiatrist, 1 Social Worker, 4LMFTS, 1 Administrative Officer
- **Expansion FY11:** Expand to Premier Medical Bldg at Austin Bluffs/Union
- **Expansion Staffing for both locations:** 2 Child Psychologists, 1 Child Psychiatrist, 2 LMFTs, 1 Social Worker, 2 Clinical Case Managers, Outreach Coordinator and administrative staff

School Behavioral Health Program (SBHP)

- **SBHP Footprint**: All Ft. Carson Schools
  4 Elementary, 1 Middle, 5 CDCs
- **Population:** Children and family members of AD personnel
- **Current Staffing**
  - Director: Clinical Psychologist
  - 1 Child Psychiatrist
  - 1 Medical Services Assistant
- **Implemented:** Aug 2010
- **Location:** Mountainside Elementary initial start-up school
- **FY11 Funded Growth**:
  - All Ft Carson schools have designated office space and support for their provider
  - Funded positions will place providers in every school
  - 1 Child Psychologists/ 4 Social Workers
  - 1 Health Systems Administrator
- **Start Date for Additional Schools:** Aug 2011

CAFAC and SBHP Services

- Crisis Walk-in Services
- Marital therapy
- Individual – adult/adolescent/child
- Group therapy
- Family therapy
- Medication services
- Substance Abuse component
- Diagnostic testing and evaluation of childhood disorders
- Outreach Services/Liaison
- ACS services (psycho-educational, health promotion, etc)
- Prevention/Wellness programs
- Consultative Services

Statistics as of Jan 31, 2011 (since 9/11)

- 2.2 million service members in Active Duty (AD), Guard and Reserve
  - 32% smaller than 1990 Operation Desert Storm
  - ~ 1.9 million children have at least one parent in the military
  - 1.6 million service members have served at least 1 tour in Iraq or Afghanistan
    - 34% served more than 1 tour (some up

Statistics as of Jan 31, 2011 (since 9/11)

- Iraq
  - Deaths 4422
  - Wounded in action 32,012
- Afghanistan
  - Deaths 1437
  - Wounded in action 9971
- Total deaths 5859
- Total wounded 41,983

http://siadapp.dmdc.osd.mi

The Military population is vulnerable yet exceptional

- Frequent moves
  - Disruption of family, social network
  - Students change schools
  - Teachers PCS or deploy
- Repeat combat deployments
- Media
  - Coverage of wartime events challenging
- Resilience of the military child and family
  - More frequent relocation experience equals better child adjustment (Weber, 2010)

Children on the Homefront: The Experience of Children from Military Families

- RAND commissioned by National Military Family Association (NMFA) surveyed 1,500 non-deployed parents and their children participating in the 2008 Operation Purple Camps.
- The data showed that:
  - Children in military families experience emotional and behavioral difficulties above national averages
  - About 1/3 of the children reported symptoms of increased anxiety
  - Self-reported problems varied by age and gender
  - Children coped better when caregivers had better mental health
  - Living on a military installation was linked with

Deployment Effects

- Longer deployments (i.e., beyond 1 year) are more difficult and increase family problems.
- Adverse effects of stress are caused by differences between expected and actual length of deployment.
- Greater incidence of neglect of children and increased number of visits to physician for behavioral and mental health complaints.
- Changes to roles and responsibilities creates child and adolescent confusion related to their “place” in the family system.
- School-aged children are at risk for social-emotional problems (e.g., anxiety, sadness, and social isolation).
- Adolescents tend to display conduct problems.

General findings

- 1/3 of military children are at high risk for psychosocial morbidity
- Parenting stress is the most significant predictor of child psychosocial functioning
  - And perceptions of child psychosocial functioning
- Feeling supported overall positively predicted child functioning
  - Military, family, peer, church, school and community support
  - Key to promoting healthy behavior (Ternus, 2010; Flake, et al, 2009)
  - Non-local family was not a significant predictor

General Findings

- Impact of combat deployment on children tends to accumulate
  - More months of combat deployment= greater impact on child (Lester et al, 2010)

- Children who lived on base had fewer difficulties during deployment than those living off-base

Deployment and the Use of Mental Health Services among U.S. Army Wives

- Study examines the impact of deployments on military spouses.
- Sample : 6,585,224 outpatient visits by 250,626 AD wives
  - 34.7% had at least one mental health diagnosis during the study period.

- Major Findings:
  - Length of deployment associated with increased mental health diagnoses.
  - Longer deployments associated with even more mental health diagnoses.
  - Stigma contributes to avoiding seeking care –

National Guard/Reserve

- Members of the Reserve and National Guard
  - Our “citizen soldiers”
  - Live and work in civilian communities across the country
  - They do not have ready access to military-specific support mechanisms
    - often do not live near military installations

National Guard/Reserve

- Children of the Guard/Reserve
  - When Reservists or Guard members are called to active duty
    - they and their families may need to deal with changes to income, child care, and medical insurance.
    - Children and families must become “suddenly military” when a parent is activated*

*activated- called up to serve on active duty

National Guard/Reserve

- Children of Guard/Reserve Families
  - May be the only children in their schools or communities who have a military parent
  - May not have had prolonged separations before
  - Do not have the same support resources as their active duty counterparts
  - May not have established a sense of being a military family member

Military adolescent

- By age 17, military youth have attended an average of 5 schools
  - Some outside of Continental U.S. (CONUS)
- Develops resiliency and coping skills
- Limits access to high-risk behavioral influences (Klein, 2008)
- Difficulty forging new relationships on PCS
- Academic issues
- Emotional/behavioral adjustment (Lincoln, 2008)
- Differing family roles and responsibilities (McFarlane, 2009)

Predictors

- Ineffective coping skills of adolescent and remaining parent (Lincoln, 2008)
- Family cohesiveness and mother-child relationships
  - More important to psychosocial adjustment of child
  - Better resilience
- Psychosocial vulnerability is not inevitable
- When mother is deployed, there is significant increase in risk-taking behavior (Ternus, 2010)
- Pre-existing emotional problems (Klein, 2008)
- Parents with poorer mental health reported

Children (5-12 years)

- Anxiety
  - 1/3 clinically significant anxiety
    - Regardless of deployment status (Manos, 2010; Lester et al, 2010)
  - 32% exceed cutoff for “high risk”
    - 2.5 times the national norm (Flake, Davis, Johnson & Middleton, 2009)
- Cumulative length of parental deployment and parental distress
  - Correlate with child depression and externalizing behaviors (Manos, 2010)
- Attention concerns- 13%
- Difficulty sleeping- 56%
- School related- 14%
    - Dropping grades
    - Decreased interest in school
    - Teacher conflict

Children- Female/Male

FEMALE

- AD parent deployed
  - Increase in externalizing behaviors
    - And not internalizing behaviors
  - Resolves on return of parent (Manos, 2010; Lester et al, 2010)
  - Problems with reintegration
  - Girls more likely to have problems with the deployment than boys

MALE

- AD parent re-deployed (returns)
  - Increase in externalizing behaviors (Manos, 2010; Lester et al, 2010)

Young children

- Active duty, Guard and Reserve
- No single, simple effect
- Increased behavior problems started at deployment
- Behavior changes increase by number of deployments and number of months deployed
- Attachment problems occurred at reunion
  - Worsened with each successive deployment (Barker & Berry, 2009)

Young children

- Child behavior problems during deployment
  - Associated with individual child factors
    - Temperament
      - “Anxious”, “difficult “ had more problems
    - Pre-deployment attachment
    - Pre-deployment behavior
    - Age of the child

Young child: Predictors

- Ameliorate when present
- Accentuate when absent
  - Personality- flexible, cooperative
  - Disposition
  - Positive mood
  - Parent support- warmth and family cohesion
  - Community support- strengthen coping, role models

Parents of children

- Anxiety
  - ¼ of parents with a deployed spouse
  - For the parents this decreased on reintegration
- Parental distress
  - Correlates with child symptoms (Manos, 2010)
  - 42% had high levels of stress
    - significantly higher than national norm
- Employment and higher levels of education
  - Correlated with significantly less parenting stress (Flake et al, 2009)

Positive Effects of Deployment

- Both active duty and Reserve component spouses report positive changes in their children due to deployments.

Active duty:

Closeness of family members

Pride in having a military parent

Increased level of responsibility

Reserve Component:

Pride in having a military parent

Closeness of family members

Increased level of responsibility

How can we help

- Most support needed during deployment and upon reintegration
  - Targeted support

- Support for families with traumatic injuries

- Highly stress families have a hard time participating in organized interventions

Social Support

- Supportive social relationships are a resilience factor critical to healthy family coping
- Spouses who report more social support also report less stress.
- Children and adolescents who feel supported by others cope better.
- Sense of community is predicted by unit support and informal community support
- National Guard and Reserve families are widely dispersed and typically do not have access to the same level of informal community support
- Although 70% of Reserve component spouses report that support from their military community is important when coping with deployments.

Role of the School

- Provide support for military families
  - Emotional and social support (Ternus, 2010)
- Staff training to recognize problems
- Give children a forum to discuss deployment related issues and stressors
- A good school environment provides established routine and structure
  - Minimizes child stress
  - A positive school climate improves academic performance
  - Influences emotions and student behavior

Take Away Messages from Research

- There are signs of increasing stress on spouses and children relative to length of deployment, safety, number of deployments.
- Potential for greater marital stress = interventions which target marital strengths and enhancement BEFORE the service member returns
- Target Strengths of families and individuals to develop and support their resiliency and well-being
- Target Positive effects to build strength and continued resiliency

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ISFAC
Inter-Service Family Assistance Committee

OPERATION: MILITARY KIDS
MILITARY FAMILIES IN OUR OWN BACKYARD.

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